LINDA LINGLE
GOVERNOR OF HAWAII

CHIYOME L. FUKINO, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

March 18, 2008

Dear Hawaii Health Care Provider:

I am writing to inform you that there has been a change in Hawaii's Administrative Rules that requires HIV reporting by patient name, effective March 13, 2008. All health care providers in Hawaii now need to report each HIV case by patient name together with patient demographics and other information. Laboratories are now required to report HIV positive results, any levels of HIV viral load, and CD4 test results by the patient's name. Providers will no longer report HIV cases using the unnamed test code (UTC) as they have over the past five years. AIDS cases will continue to be reported by name as they have been since 1983.

Providers of the Hawaii Seroprevalence and Medical Management Program (HSPAMM) and clinical trial patients will continue to order lab tests using HSPAMM or clinical trial codes as they do currently. Laboratories will report results using these codes, but providers are responsible for reporting the cases to DOH using the patient's name and not a code number.

Physicians providing services to HIV/AIDS patients must report ALL cases of HIV ever diagnosed in Hawaii or elsewhere, whether living or deceased. This means reporting all previous HIV cases, as well as new cases as they are diagnosed. The aim is to collect all possible cases, which will be reported without identifying information to CDC. The funding allocation of the Ryan White CARE Act, which supports HIV/AIDS care services in Hawaii is calculated based on our reported HIV/AIDS cases. Each valid case report increases federal funding for Hawaii's entire HIV community. According to the updated Hawaii Administrative Rules, failure to report is considered a misdemeanor.

The HIV/AIDS Surveillance staff is working to convert your HIV cases previously reported by UTC to named reports. To facilitate this conversion and reduce the need for you to re-report cases I am requesting that you provide them with the following:

1. A copy of your completed HIV provider Name/code Log form (sample attached) and/or
2. Submit the top tear off portions of your used UTC report forms or
3. Submit a list of all HIV cases (current and past) that are/were under your care with the following information: Physician name, Patient name, Medical record number (if available, especially for hospital in or out patient), Date of birth, Sex, and Date of death (if applicable).

This information is essential to accurately match and convert existing UTC reports to named HIV reports. Our HIV surveillance staff will work together with your office to ease this transition and answer questions.

All HIV/AIDS reporting is strictly confidential and HIV reports are protected with the same high level of security that AIDS reports have been maintained at for many years.

A question and answer sheet on named HIV reporting and sample HIV report form (same as AIDS report form) are attached. HIV reporting requirements are found in Hawaii Administrative Rules, Chapter 11-156 Exhibit A and B. Please, submit copies of your Name/Code Log form and new reports using a confidential envelope to: HIV/AIDS Surveillance Program, STD/AIDS Prevention Branch, 3627 Kilauea Avenue, Suite 306, Honolulu, HI 96816. Please call surveillance staff at 808-733-9010, if you need any assistance.

Each reported HIV/AIDS case brings care services funding to Hawaii and provides information that helps us allocate our limited HIV resources. I gratefully acknowledge your work providing HIV services and your collaboration as we transition to named HIV reporting in Hawaii.

Sincerely,

Glenn M. Wasserman, M.D., M.P.H.
Chief, Communicable Disease Division

Attachments:
Question and Answer Sheet
Name/Code Log Form
HIV/AIDS report form

Named HIV Reporting in Hawai, March 13, 2008

Questions and Answers for Health Care Providers

When will named HIV reporting begin?

Beginning on March 13, 2008, Hawaii Administrative Rules, Chapter 156 will require that HIV infection be reportable by patient name to the Hawaii Deparatment of Health.

Who should report HIV cases?

Any physician or other health care provider that requested HIV testing must report positive HIV cases. Laboratories must report all test results by name for HIV+, all levels of HIV viral load and CD4. In-state laboratories that perform the HIV testing will be responsible for reporting. Laboratories that outsource HIV tests to out-of-state testing sites will be responsible for reporting the HIV test results.

Which test results need to be reported?

Providers and laboratories report the following:

1. A confrmatory HIV Western blot result or HIV-IFA.
2. Positive HIV detection test (HIV+ culture, antigen, PCR, DNA or RNA probe)
3 Other test(s) indicative of HIV as defined by the Center of Disease Control and Prevention (CDC).

Laboratories will also report the following:

4. All HIV viral load tests (NASBA, RT-PCR, bDNA, others)
5. All levels of CD4 tests

How do I report?

Providers will use the standard CDC HIV/AIDS report form (same form for HIV and for AIDS) to report to the HIV/AIDS Surveillance Program. Report in a confidential envelope for security purposes. You can also report by telephone to 808-733-9010. You may NOT report by fax or email.

Where should providers report?

Department of Health
Surveillance Program
3627 Kilauea Avenue, Suite 306
Honolulu, Hawai'i 96816

Does the date of HIV diagnosis affect the need to report by name?

All HIV positive cases need to be reported by name regardless of when they were diagnosed, either before or after March 13, 2008. Both prevalent (previously diagnosed) and incident (newly diagnosed HIV cases are to be reported. Cases that have already been reported as AIDS cases do NOT have to be reported for HIV.

Does a patient transferring from another physician need to be reported?

The Administrative Rules require providers to report all HIV/AIDS cases (including those who may or may not have been diagnosed by other physicians in Hawaii or elsewhere). Duplicate reports will be eliminated by surveillance staff at the time of report. Therefore each positive case does need to be reported.

Is there any way to assist me to report by name all the HIV cases I've previously reported by UTC?

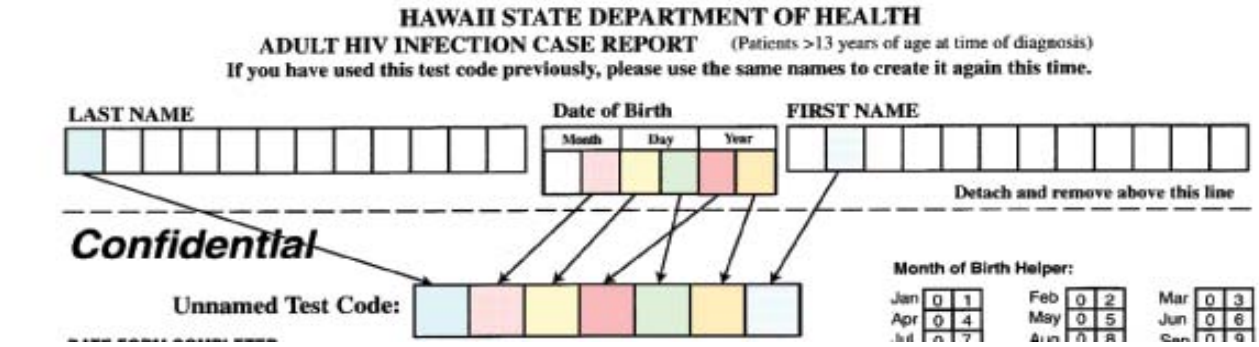
Yes, the surveillance program staff will convert cases that were reported previously by UTC into named reports, but they need specific information from you to do so. Please save time by submitting one of the following to the HIV/AIDS Surveillance Program:

1. Submit the Provider's Name/code Log form (example below) that provides a listing of your already reported patients including: patient name, DOB, UTC and date of report to DOH. (copy attached)

Provider's Name/code Log
Doctor's Name: Hello, Hawaii

Name of Patient Last, First and MI	Date of Birth	UTC	Other Codes	Date of Report to DOH Surveillance	
				HIV	AIDS
My, Name	04/12/1947	M41427A		04/11/2003	
Your, Name	02/12/1947	Y21427A		01/01/2002	04/16/2002

2. Submit the tear off, top portions of your used UTC report forms and include provider name on the top.



3. Submit a list of all HIV cases (current and past) that are/were under your care with the following variables: MD's name, Patient name, Medical record number (if available especially for hospital in or out patient), DOB, Sex, Date of death (if applicable).

The Hawai'i HIV/AIDS Surveillance Program will work with individual providers and health care facilities that request assistance. Please call the HIV/AIDS Surveillance Program at (808) 733-9010.

Why is HIV reporting needed?

Named HIV reporting will improve Hawaii's ability to understand the epidemic, to provide the data needed to design targeted prevention programs and to fund appropriate services for those living with the disease. Named HIV reporting is required for Hawaii to receive federal funding for care services. Funds are allocated according the number of reported HIV and AIDS cases.

Is AIDS still reportable?

Yes, AIDS is still reportable by name. AIDS data allows us to monitor access to care among persons with HIV infection and to continue to monitor the full spectrum of HIV disease. Providers should continue to update us on the clinical status of HIV/AIDS patients, including AIDS defining conditions, deaths, and relocation out of state. Once HIV patient develop AIDS then need to be reported separately as AIDS.

How will the security and confidentiality of reported HIV/AIDS be assured?

The HIV/AIDS Surveillance program has maintained absolute confidentiality of AIDS case infomation at all times since 1983. HIV case reports will be maintained under the same standard of security and confidentiality. The Department of Health releases only statistical data with no information that could identify individuals.

This document provides the answers to "Frequently Asked Questions" about Hawaii's named HIV reporting requirement. Additional information is available from the Hawai'i HIV/AIDS Surveillance Program at (808) 733-9010 or email pritty.borthakur@doh.hawaii/gov or sandy.giu@doh.hawaii.gov

Name/Code Log

Doctor's Name: ______________________________

Name of Patient	Date of Birth	UTC	Other Code	Date of Report to DOH Surveillance	
Last, First and MI	mm/dd/yy			HIV	AIDS

I. STATE/LOCAL USE ONLY

Patient's Name: _____ Phone No.: ( ) _____
(Last, First, M.I.)

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT — ***– Patient identifier information is not transmitted to CDC! –***

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients ≥13 years of age at time of diagnosis)

CDC — Centers for Disease Control and Prevention

II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0573 Exp Date 11/30/2005

DATE FORM COMPLETED: Mo. Day Yr.

REPORT SOURCE:

SOUNDEX CODE:

REPORT STATUS: 1 New Report; 2 Update

REPORTING HEALTH DEPARTMENT: State: _____ City/County: _____

State Patient No.:

City/County Patient No.:

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT (check one): 1 HIV Infection (not AIDS); 2 AIDS

AGE AT DIAGNOSIS: _____ Years _____ Years

DATE OF BIRTH: Mo. Day Yr.

CURRENT STATUS: Alive 1 Dead 2 Unk. 9

DATE OF DEATH: Mo. Day Yr.

STATE/TERRITORY OF DEATH: _____

SEX: 1 Male; 2 Female

ETHNICITY: (select one) 1 Hispanic 9 Unk; 2 Not Hispanic or Latino

RACE: (select one or more) American Indian/Alaska Native; Black or African American; Asian; Native Hawaiian or Other Pacific Islander; White; Unk

COUNTRY OF BIRTH: 1 U.S. 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____ 8 Other (specify): _____ 9 Unk

RESIDENCE AT DIAGNOSIS:
City: _____ County: _____ State/Country: _____ Zip Code: _____

IV. FACILITY OF DIAGNOSIS

Facility Name _____

City _____

State/Country _____

FACILITY SETTING (check one)
1 Public 2 Private 3 Federal 9 Unk.

FACILITY TYPE (check one)
01 Physician, HMO 31 Hospital, Inpatient
88 Other (specify): _____

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

V. PATIENT HISTORY

AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD (Respond to **ALL** Categories)**:**

	Yes	No	Unk.
• Sex with male	1	0	9
• Sex with female	1	0	9
• Injected nonprescription drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9
Specify disorder: 1 Factor VIII (Hemophilia A) 2 Factor IX (Hemophilia B) 8 Other (specify): _____			
• *HETEROSEXUAL* relations with any of the following:			
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
First Mo. Yr. Last Mo. Yr.			
• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health-care or clinical laboratory setting	1	0	9
(specify occupation): _____			

VI. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate first test)

	Pos	Neg	Ind	Not Done	TEST DATE Mo.	Yr.
• HIV–1 EIA	1	0	–	9		
• HIV–1/HIV–2 combination EIA	1	0	–	9		
• HIV–1 Western blot/IFA	1	0	8	9		
• Other HIV antibody test (specify): _____	1	0	8	9		

2. POSITIVE HIV DETECTION TEST: (Record earliest test) Mo. Yr.

☐ culture ☐ antigen ☐ PCR, DNA or RNA probe

• Other (specify): _____

3. DETECTABLE VIRAL LOAD TEST: (Record most recent test)

Test type* COPIES/ML Mo. Yr.

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

• Date of last documented negative HIV test (specify type): _____ Mo. Yr.

• If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? Yes 1 No 0 Unk. 9

If yes, provide date of documentation by physician Mo. Yr.

4. IMMUNOLOGIC LAB TESTS:

AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS

	Mo.	Yr.
• CD4 Count ____,___ cells/μL		
• CD4 Percent ____ %		

First <200 μL or <14%

	Mo.	Yr.
• CD4 Count ____,___ cells/μL		
• CD4 Percent ____ %		

VII. STATE/LOCAL USE ONLY

Physician's Name: _____ Phone No.: ( ) _____ Medical Record No. _____
(Last, First, M.I.)

Hospital/Facility: _____ Person Completing Form: _____ Phone No.: ( ) _____

– Patient identifier information is not transmitted to CDC! –

VIII. CLINICAL STATUS

CLINICAL RECORD REVIEWED: Yes [1] No [0]

ENTER DATE PATIENT WAS DIAGNOSED AS: Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy): Mo. Yr. | Symptomatic (not AIDS): Mo. Yr.

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Candidiasis, bronchi, trachea, or lungs	[1]	NA		
Candidiasis, esophageal	[1]	[2]		
Carcinoma, invasive cervical	[1]	NA		
Coccidioidomycosis, disseminated or extrapulmonary	[1]	NA		
Cryptococcosis, extrapulmonary	[1]	NA		
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	[1]	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes)	[1]	NA		
Cytomegalovirus retinitis (with loss of vision)	[1]	[2]		
HIV encephalopathy	[1]	NA		
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	[1]	NA		
Histoplasmosis, disseminated or extrapulmonary	[1]	NA		
Isosporiasis, chronic intestinal (>1 mo. duration)	[1]	NA		
Kaposi's sarcoma	[1]	[2]		
Lymphoma, Burkitt's (or equivalent term)	[1]	NA		
Lymphoma, immunoblastic (or equivalent term)	[1]	NA		
Lymphoma, primary in brain	[1]	NA		
Mycobacterium avium complex or *M.kansasii,* disseminated or extrapulmonary	[1]	[2]		
M. tuberculosis, pulmonary*	[1]	[2]		
M. tuberculosis, disseminated or extrapulmonary*	[1]	[2]		
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	[1]	[2]		
Pneumocystis carinii pneumonia	[1]	[2]		
Pneumonia, recurrent, in 12 mo. period	[1]	[2]		
Progressive multifocal leukoencephalopathy	[1]	NA		
Salmonella septicemia, recurrent	[1]	NA		
Toxoplasmosis of brain	[1]	[2]		
Wasting syndrome due to HIV	[1]	NA		

Def. = definitive diagnosis Pres. = presumptive diagnosis

* RVCT CASE NO.: _____

- **If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?** [1] Yes [0] No [9] Unknown

IX. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? [1] Yes [0] No [9] Unk.

This patient's partners will be notified about their HIV exposure and counseled by:
[1] Health department [2] Physician/provider [3] Patient [9] Unknown

This patient is receiving or has been referred for:

	Yes	No	NA	Unk.
• HIV related medical services	[1]	[0]	–	[9]
• Substance abuse treatment services	[1]	[0]	[8]	[9]

This patient received or is receiving:

	Yes	No	Unk.
• Anti-retroviral therapy	[1]	[0]	[9]
• PCP prophylaxis	[1]	[0]	[9]

This patient has been enrolled at:

Clinical Trial	Clinic
[1] NIH-sponsored	[1] HRSA-sponsored
[2] Other	[2] Other
[3] None	[3] None
[9] Unknown	[9] Unknown

This patient's medical treatment is primarily reimbursed by:
[1] Medicaid [2] Private insurance/HMO
[3] No coverage [4] Other Public Funding
[7] Clinical trial/ government program [9] Unknown

FOR WOMEN:
- This patient is receiving or has been referred for gynecological or obstetrical services: [1] Yes [0] No [9] Unknown
- Is this patient currently pregnant? [1] Yes [0] No [9] Unknown
- Has this patient delivered live-born infants? [1] Yes (if delivered after 1977, provide birth information below for the most recent birth) [0] No [9] Unknown

CHILD'S DATE OF BIRTH: Mo. Day Yr.

Hospital of Birth: _____

City: _____ State: _____

Child's Soundex: _____

Child's State Patient No.

X. COMMENTS: _____

RACE/ETHNIC BACKGROUND FORM
FOR ASIANS OR HAWAIIAN/ PACIFIC ISLANDERS

Please mark ALL *the appropriate boxes with an X.*

ASIANS:

01	Japanese
02	Filipino
03	Chinese
06	Korean
17	Vietnamese
18	Laotian
19	Thai
20	Cambodian
21	Indonesian
22	Asian Indian
23	Other Asian
24	Pakistani
25	Malaysian

HAWAIIAN / PACIFIC ISLANDERS:

04	Hawaiian
07	Samoan
08	Guamanian
09	Tongan
10	Fijian
11	Marshallese
12	Micronesian
13	Tahitian
14	Northern Mariana
15	Palauan
16	Other Pac. Islander
26	Polynesian